

EXHIBIT 1

Declaration of Joe Goldenson, MD

1. I am a medical physician with 33 years of experience in correctional health care. For 28 years, I worked for Jail Health Services of the San Francisco Department of Public Health. For 22 of those years, I served as the Director and Medical Director. In that role, I provided direct clinical services, managed public health activities in the San Francisco County jail, and administered the correctional health enterprise, including its budget, human resources services, and medical, mental health, dental, and pharmacy services.
2. I served as a member of the Board of Directors of the National Commission on Correctional Health Care for eight years and was past President of the California chapter of the American Correctional Health Services Association. In 2014, I received the Armond Start Award of Excellence from the Society of Correctional Physicians, which recognizes its recipient as a representative of the highest ideals in correctional medicine.
3. For 35 years, I held an academic appointment as an Assistant Clinical Professor at the University of California, San Francisco.
4. I have worked extensively as a correctional health medical expert and court monitor. I have served as a medical expert for the United States District Court for the Northern District of California for 25 years. I am currently retained by that Court as a medical expert in *Plata v. Newsom*, Case No. 3:01-cv-01351 (N.D. Cal.), to evaluate medical care provided to inmate patients in the California Department of Correctional Rehabilitation. I have also served as a medical expert/monitor at Cook County Jail in Chicago and Los Angeles County Jail, at other jails in Washington, Texas, and Florida, and at prisons in Illinois, Ohio, and Wisconsin.

The nature of COVID-19

5. The SARS-nCoV-2 virus, and the human infection it causes, COVID-19 disease, is a global pandemic and has been termed a global health emergency by the WHO. Cases first began appearing sometime between December 1, 2019 and

December 31, 2019 in Hubei Province, China. Most of these cases were associated with a wet seafood market in Wuhan City.

6. On January 7, 2020, the virus was isolated. The virus was analyzed and discovered to be a coronavirus closely related to the SARS coronavirus which caused the 2002-2003 SARS epidemic.
7. COVID-19 is a serious disease. The overall case fatality rate has been estimated to range from 0.3 to 3.5%, which is 5-35 times the fatality associated with influenza infection. COVID-19 is characterized by a flu-like illness. While more than 80% of cases are self-limited and generally mild, overall some 20% of cases will have more severe disease requiring medical intervention and support.
8. The case fatality rate varies significantly depending on the presence of certain demographic and health factors. The case fatality rate varies significantly with advancing age, rising after age 50, and above 5% (1 in 20 cases) for those with pre-existing medical conditions including cardio-vascular disease, respiratory disease, diabetes, and immune compromise.
9. Among patients who have more serious disease, some 30% will progress to Acute Respiratory Distress Syndrome (ARDS) which has a 30% mortality rate overall, higher in those with other health conditions. Some 13% of these patients will require mechanical ventilation, which is why intensive care beds and ventilators have been in insufficient supply in Italy, Iran, and in parts of China.
10. COVID-19 is widespread. Since it first appeared in Hubei Province, China, in late 2019, outbreaks have subsequently occurred in more than 160 countries and all populated continents, heavily affected countries include Italy, Spain, Iran, South

Korea, and the US. The U.S. is now the world's most affected country. As of April 3, 2020, there have been 972,303 confirmed human cases globally and 50,322 known deaths. The pandemic has been termed a global health emergency by the WHO. It is not contained and cases are growing exponentially.

11. In the United States alone, the CDC reports 239,279 cases and 5,443 deaths as of April 3, 2020. The Louisiana Department of Health reports 10,297 cases and 370 dead as of April 3. All these numbers are likely underestimates because of limited availability of testing.
12. SARS-nCoV-2 is now known to be fully adapted to human-to-human spread. This is almost certainly a new human infection, which also means that there is no pre-existing or "herd" immunity, allowing for very rapid chains of transmission once the virus is circulating in communities.
13. The U.S. CDC estimates that the reproduction rate of the virus, the R_0 , is 2.4-3.8, meaning that each newly infected person is estimated to infect on average 3 additional persons. This is highly infectious and only the great influenza pandemic of 1918 (the Spanish Flu as it was then known) is thought to have higher infectivity. This again is likely a function of all human populations currently being highly susceptible. The attack rate given an exposure is also high, estimated at 20-30% depending on community conditions, but may be as high as 80% in some settings and populations. The incubation period is thought to be 2-14 days, which is why isolation is generally limited to 14 days.
14. There is currently no vaccine for COVID-19, and no cure. The only known ways to prevent the spread of SARS-nCoV-2 involve measures such as thorough

handwashing, frequent decontamination of surfaces, and maintaining six feet of physical distance between individuals (“social distancing”).

The risks of COVID-19 in detention facilities

15. COVID-19 poses a serious risk to prisoners, workers, and anyone else in detention facilities. Detention facilities, including prisons like Oakdale, have long been associated with high transmission probabilities for infectious diseases, including tuberculosis, multi-drug resistant tuberculosis, MRSA (methicillin resistant staph aureus), and viral hepatitis.
16. The severe epidemic of Tuberculosis in prisons in Central Asia and Eastern Europe was demonstrated to increase *community* rates of Tuberculosis in multiple states in that region, underscoring the risks prison outbreaks can lead to for the communities surrounding a prison.
17. Infections that are transmitted through droplets, like influenza and SARS-nCoV-2 virus, are particularly difficult to control in detention facilities, as social distancing and proper decontamination of surfaces is virtually impossible.
18. For example, several deaths were reported in the US in immigration detention facilities associated with ARDS following influenza A, including a 16-year old male immigrant child who died of untreated ARDS in custody in May 2019.
19. A number of features of these facilities can heighten risks for exposure, acquisition, transmission, and clinical complications of these infectious diseases. These include physical/mechanical risks such as overcrowding; population density in close confinement; insufficient ventilation; shared toilet, shower, and eating environments; and limits on hygiene and personal protective equipment

such as masks and gloves in some facilities. Limits on soap (copays are common) and hand sanitizer, since they can contain alcohol, are also risks for spread.

20. Additionally, the high rate of turnover and population mixing of staff and detainees increases likelihoods of exposure. This has led to prison outbreaks of COVID-19 in multiple detention facilities in China, associated with introduction into facilities by staff. The current outbreak in the detention facility of Riker's Island in New York City is an example—and in the first days of that outbreak, the majority of cases were among prison staff, not inmates.
21. In addition to the nature of the prison environment, prison and jail populations are also at additional risk due to high rates of chronic health conditions, substance use, mental health issues, and, particularly in prisons, aging and chronically ill populations who may be vulnerable to death or severe illnesses after infection from COVID-19 disease.
22. While every effort should be made to reduce exposure in detention facilities through internal mitigation efforts, this may be extremely difficult to achieve and sustain quickly enough. It is therefore an urgent priority in this time of national public health emergency to reduce the number of persons in detention as quickly as possible.
23. Given the experience in China as well as the literature on infectious diseases in jail, additional outbreaks of COVID-19 among the U.S. jail and prison populations are inevitable, as evidenced in Oakdale. Releasing as many inmates as possible is important to protect the health of inmates, correctional facility staff, health care workers at jails and other detention facilities, the community as a

whole. Indeed, according to the World Health Organization, “enhanced consideration should be given to resorting to non-custodial measures at all stages of the administration of criminal justice, including at the pre-trial, trial and sentencing as well as post-sentencing stages.”¹

24. From news reports, it is my understanding that 5 prisoners have died at FCI Oakdale. 18 detainees and 17 staff members have COVID-19, and that dozens more have symptoms. Even these dozens may represent the tip of the iceberg, since newly-infected people typically do not show symptoms for 2-14 days, and since the infection spreads rapidly to additional people. News outlets have reported that four detainees have already died from COVID-19 in FCI Oakdale. Given the way the disease has progressed elsewhere, we can expect the death toll to mount rapidly.

25. It is my understanding that FCI Oakdale has five open bay / dorm housing units, eight housing units with multiple-occupancy cells, and no housing units with single occupancy cells, but a number of segregation units. It also my understanding that FCI Oakdale may have upward of 100 new admissions in a given month and roughly 1,700 detainees in the facility on any given day; that staff that enter and leave the facility regularly; and that detainees share restroom and shower facilities and eat communally prepared food.

26. Based on these understandings, it is my opinion that the exponential infection of rate for COVID-19 we already see in the community would be magnified within

¹ World Health Organization, Regional Office for Europe, Preparedness, prevention and control of COVID-19 in prisons and other places of detention: Interim guidance (Mar. 15, 2020), http://www.euro.who.int/__data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf.

FCI Oakdale. Adequate social distancing would be impossible to maintain.

What's more, the infection in FCI Oakdale would not stay limited to the facility, but would worsen infection rates in the broader community. The death rate will increase substantially before it starts to diminish without major interventions. This is why leaving implementation in the hands of local officials alone, who lack the expertise and resources and were incapable of preventing the outbreak in the first place or treating those who eventually died, is insufficient.

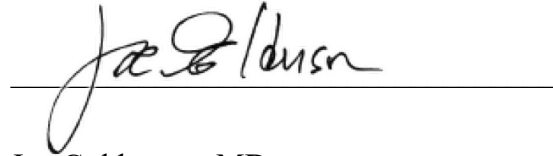
27. It is my public health recommendation that everyone who is medically-vulnerable to severe symptoms and death from COVID-19, as defined in this lawsuit,² be released from FCI Oakdale immediately, taking precautions that they are released to a place where they can maintain medically appropriate isolation for at least 14 days and receive any necessary and available testing healthcare for underlying chronic conditions.

28. It is my public health recommendation that a public health expert be appointed to oversee operations related to preventing further spread of COVID-19 in FCI Oakdale, which may include authorizing further staggered release of detainees until it is possible to maintain consistent social distancing and appropriate hygiene within the facility.

² "Persons held at Oakdale over the age of 50 , as well as all current and future persons held at Oakdale of any age who experience (a) lung disease, including asthma, chronic obstructive pulmonary disease (e.g. bronchitis or emphysema), or other chronic conditions associated with impaired lung function; (b) heart disease, such as congenital heart disease, congestive heart failure and coronary artery disease; (c) chronic liver or kidney disease (including hepatitis and dialysis patients); (d) diabetes or other endocrine disorders; (e) epilepsy; (f) hypertension; (g) compromised immune systems (such as from cancer, HIV, receipt of an organ or bone marrow transplant, as a side effect of medication, or other autoimmune disease); (h) blood disorders (including sickle cell disease); (i) inherited metabolic disorders; (j) history of stroke; (k) a developmental disability; and/or (l) a current or recent (last two weeks) pregnancy."

Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 5th day of April 2020 in Alameda County, CA

A handwritten signature in black ink, appearing to read "Joe Goldenson", is written over a horizontal line.

Joe Goldenson, MD

References

1. Dolan K, Wirtz A, Maazen B., et al. Global Burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. *The Lancet*, July 14, 2016.
2. Stuckler D, Basu S, McKee M, King I. Mass incarceration can explain population increases in TB and multi-drug resistant TB in European and Central Asian countries. *Proceedings of the National Academy of Science USA*, 2008. 105:13280-85.
3. Beyrer C, Kamarulzaman A, McKee M; Lancet HIV in Prisoners Group. Prisoners, prisons, and HIV: time for reform. *The Lancet*. 2016 Jul 14. pii: S0140-6736(16)30829-7. doi: 10.1016/S0140-6736(16)30829-7. [Epub ahead of print] No abstract available. PMID: 27427447.
4. Marusshak LM, Sabol W, Potter R, Reid L, Cramer E. Pandemic Influenza and Jail Facilities and Populations. *American Journal of Public Health*. 2009 October; 99(Suppl 2): S339–S344.
5. Nakamoto Group, Prison Rape Elimination Act Audit Report of FCC Oakdale (2017), https://www.bop.gov/locations/institutions/oak/OAK_prea.pdf.

6. Rubenstein LS, Amon JJ, McLemore M, Eba P, Dolan K, Lines R, Beyrer C. HIV, prisoners, and human rights. *The Lancet*. 2016 Jul 14. pii: S0140-6736(16)30663-8. doi: 10.1016/S0140-6736(16)30663-8
7. Wang J, Ng, CY, Brook R. Response to COVID-19 in Taiwan: Big Data Analytics, New Technology, and Proactive Testing. March 3, 2020. *JAMA*. Published online March 3, 2020. doi:10.1001/jama.2020.3151.